Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Mark Hackbarth, MD

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-06-3051-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 4, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are not billing a bilateral procedure. CPT code 63650 allows payment for each separate array (lead) that is placed, and Dr. Hackbarth placed 2 arrays. Trailblazer will pay for each array placed…"

Amount in Dispute: $239.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position the requestor improperly billed with modifier "-59."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2005	63650	$239.51	$239.51

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – Payment is included in the allowance for another service/procedure
   - 42 – Charges exceed our fee schedule or maximum allowable amount
   - 217 – The value of this procedure is included in the value of another procedure performed on this date
   - 790 – This charge was reduced in accordance to the Texas Medical Fee Guidelines

Issues

1. Did the requestor support separate payment for each procedure?
2. Did the respondent support denial of disputed service?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. The carried denied the disputed service as, 97 – "Payment is included in the allowance for another service/procedure." CPT code 63650 has the description of, "Percutaneous implantation of neurostimulator electrode array, epidural. Implantation/placement and revision/removal of each component is reported separately." The carrier's denial is not supported.

2. Per 28 Texas Administrative Code§134.202 (c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. The Physician Fee Schedule finds the following;
    a. Allowable for "Rest of Texas" is 383.22. This amount multiplied by 125% = $479.03
    b. Based on CPT coding guidelines, "Multiple Procedure Reduction Guidelines Apply" or $479.03 x 50% = $239.51
3. Review of the submitted documentation finds that the Maximum Allowable Reimbursement is $239.51. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $239.51

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $239.51 plus applicable accrued interest per 28 Texas Administrative Code §134.130due within 30 days of receipt of this Order.

Authorized Signature

		August , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.